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# Selling Organs: The Answer to the Burgeoning Organ Deficit

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## Introduction

In the last fifty years, the innovation in procedure and the development of new drugs has enabled those receiving organ transplants to live longer and healthier lives. Ironically, these gains in the efficacy of organ transplantation have also resulted in a significant number of people dying potentially preventable deaths than they would have had these gains never been realized. Those that die, die for want of organs, organs that could potentially be more easily available. So instead of passing away their remaining days resigned to the lack of solutions and the inevitability of their imminent death, patients in need of transplants, hang precariously on organ waitlists fighting time and disease while they frustratingly try to discern whether the life-saving organ and transplant procedure laying, seemingly right in front of their eyes, is a mirage or not. The ever-widening gap between the escalating demand and the stagnant supply of organs has been screaming for national reform for at least two decades. Furthermore, the weak and narrow-minded responses by the federal government, most importantly, the law prohibiting donors from receiving valuable consideration, borders on scandalous when one considers that these federal responses have been wholly ineffective for years.

**In the United States, just over 79,000 people currently need organ transplants.<sup>1</sup> Of that 79,000, roughly 75% or 58,500, will be dead and buried before their turn comes to receive a transplant.<sup>2</sup> This works out to fifteen people dying everyday waiting for organs that never become available for transplant.<sup>3</sup> In reaction to these harrowing statistics the American Medical Association's Council on Ethical and Judicial Affairs convened in December of 2001 to study possible solutions to alleviating the lack of transplantable organs. When it came to pursuing a means of somehow compensating those that donated their organs, the Council split down**

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<sup>1</sup>See United Network of Organ Sharing, Newsroom, Critical Data (visited February 5, 2002) <[http://www.unos.org/Frame\\_default.asp?Category=Newsdata](http://www.unos.org/Frame_default.asp?Category=Newsdata)>.

<sup>2</sup>See Paul Elias, "Debate Over Organ-Donor Pay Issue," Associated Press (visited January 22, 2002) <[http://seattlepi.nwsource.com/national/49010\\_organ03.shtml](http://seattlepi.nwsource.com/national/49010_organ03.shtml)>.

<sup>3</sup>*Id.*

the middle on whether to even study the issue.<sup>4</sup> Only a short time ago, the U.S. Secretary of Health and Human Services, Tommy Thompson, convened an advisory committee to study the idea of compensating the families of deceased donors. Yet in response to an onslaught of criticism from media-savvy conservatives for even having the federal government broach the subject, further study of the practical implications of the idea has been shelved.<sup>5</sup>

Despite the outwardly strong controversy of compensating donors for their organs, it is apparent that, at the very least, the federal government, the primary entity that can effect change and ameliorate the lack of supply of transplantable organs, has realized that the status quo is currently letting fifteen people die unnecessary, tragic deaths everyday. Unfortunately, especially for those patients on waiting lists, the government does not seem even remotely close to instituting the rational, functional answer that can easily address the supply problem – repealing the federal law against donors receiving compensation for their organs. Furthermore, there are signs, as exhibited in editorials and select television reports that a majority of the American populace is slowly shedding its total aversion to donors receiving compensation for their organs. This paper advocates a free market based approach to organ donation with a small degree of government regulation to prevent abuse. In realization of the vociferous yet misguided opposition to implementing such a solution, this paper supports, as the next best practical alternative, the federal government, at a minimum, enabling deceased donors to receive compensation for their organs.

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<sup>4</sup>See Anne Barnard, “Cash for Organs: Doctors Consider a Loaded Idea,” Boston Globe (visited January 22, 2002) <[http://www.boston.com/dailyg.../Cash\\_for\\_organ\\_Doctors\\_consider\\_a\\_loaded\\_idea+.shtm](http://www.boston.com/dailyg.../Cash_for_organ_Doctors_consider_a_loaded_idea+.shtm)>.

<sup>5</sup>*Id.*

## Transplant History

Although the first transplants were conducted over forty years ago,<sup>6</sup> it is only twenty years ago, on the heels of the introduction of the drug Cyclosporin-A in 1980, that transplants have become a viable means to cure diseased organs. The development of Cyclosporin-A, an immuno-suppressant, enabled patients receiving transplants to avoid the self-destructive responses of their immune systems and thereby live longer than a few weeks to months that they would have absent the drug.<sup>7</sup> In addition to the introduction of Cyclosporin-A, medical professionals and hospitals improved their harvesting techniques and maintenance of harvested organs.<sup>8</sup> In other words, procedures for removing and preserving organs improved thereby increasing the viability of these organs when transplanted. These medical innovations in drugs and procedure led to increased survival rates for transplant recipients, which in turn increased the demand for transplants and organs. This leads us up to the present where, ironically, as the drugs and techniques are consistently being refined, thereby improving the effectiveness of transplant operations and increasing the demand for organs, the available supply of organs remains stagnant.

## Alternatives

Considering the ever-widening gap between the supply of organs and demand, it is no wonder that there

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<sup>6</sup>See David E. Jefferies, *The Body as Commodity: The Use of Markets to Cure the Organ Deficit*, 5 Ind. J. Global Legal Stud. 621, 623 (1998) (The first successful live kidney transplant was conducted in the United States in 1956).

<sup>7</sup>See Curtis E. Harris, et. al, *To Solve a Deadly Shortage: Economic Incentives for Human Organ Donation*, 16 Issues L. & Med. 213, 214 (2001) (Cyclosporin increased survival rates 25% to 50% depending on the tissue type).

<sup>8</sup>See Jefferies, 5 Ind. J. Global Legal Stud. at 623.

have been alternate efforts to investigate other possible sources of organs besides human transplants. Xenotransplantation, organs transplanted from animals, has been investigated and attempted with little success. Transplant patients receiving organs from primates, pigs, etc., almost always experience a hyper acute immune response that leaves them dead within days of the transplant.<sup>9</sup> It is highly debatable whether any drug therapy will ever be able to make xenotransplantation a feasible means to address the lack of supply of transplantable organs.

Perhaps the most sensible means to increase the supply of organs is to manufacture them. Bioengineers have been vigorously pursuing techniques to produce viable human organs from stem cells, for example, and while early research shows promise, even the most optimistic bioengineers admit that the clinical application of biologically manufacturing organs is at least twenty years away.<sup>10</sup> Mechanical organs, i.e. those lacking living cells, have also been developed, most notably the mechanical heart and kidney. Yet each of these fail from a practical standpoint; the mechanical heart is only intended to serve as a stand-in for a biological heart<sup>11</sup> whereas the mechanical kidney is the size of desk top computer.<sup>12</sup> Despite the potential, manufacturing organs is not an achievable solution for solving the organ supply crisis in the short-term.

## The Supply Problem

The dearth of organs in the United States is a problem of lacking an adequately available supply not of

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<sup>9</sup>See Franklin Hoke, "As Cross-Species Transplantation Move Ahead, Some Scientists Call For Caution, Restraint", The Scientist, (visited January 23, 2002) <<http://www.the-scientist.com/newsarchive.htm>>.

<sup>10</sup>See Amy Contrada, "Manufacturing Human Beings in Worcester?", Massachusetts News, (visited February 20, 2002) <<http://www.massnews.com/8151amylead.htm>>.

<sup>11</sup>See "Artificial Heart is Mechanical First", BBC News, (visited February 20, 2002) <[http://news.bbc.co.uk/1/hi/english/health/newsid\\_1420000/1420737.stm](http://news.bbc.co.uk/1/hi/english/health/newsid_1420000/1420737.stm)>.

<sup>12</sup>See Josie Glausiusz, "Spare Parts", Discover, (visited January 22, 2002) <<http://www.britannica.com/bcom/magazine/article/print/0,5746,00.h>>.

potential supply. For instance, twenty thousand usable cadavers, each with at least one transplantable organ, are buried annually.<sup>13</sup> These twenty thousand cadavers alone represent a highly valuable untapped potential supply of more organs for transplant which could greatly alleviate the organ deficit in the United States. This difference between available supply and potential supply underlines the organ supply problem in the United States. Unlike the supply of sunlight for instance, where the available supply equals the potential supply, there is a gross disparity between the number of organs the United States has available for supply and what it could potentially have. In other words, the supply of organs is there to adequately satisfy demand, yet it is simply not captured and utilized. Clearly the most glaring source of untapped supply is live donors who have been discouraged from donating due to the lack of incentives and nebulous ethical considerations. Furthermore, outside of live donors, there remains a significant supply of transplantable organs from deceased donors but again, incentives and procedures have not been put in place to realize this supply. In both cases, with both living and deceased donors, potential supply is not captured because the government has retarded and diminished the abilities and incentives of suppliers (i.e. those living and deceased donors), to meet this demand. Therefore, in order to rectify the supply problem of transplantable organs one must remedy the framework the United States government has put in place to provide transplantable organs. To understand why there are fifteen people dying everyday due to lack of organs one must look at the current federal legislative approach to the organ supply problem.

## The Legislative Approach

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<sup>13</sup>Gregory S. Crespi, *Overcoming the Legal Obstacles to the Creation of a Futures Market in Bodily Organs*, 55 Ohio St. L. J. 1, 9 (1994).

The current organ donation framework in the United States is based on a policy of “encouraged volunteerism.”<sup>14</sup> This policy acknowledges lawful organ donation when the donor has freely (i.e. without being coerced) decided to donate his organ(s) for transplantation or other medical research purposes.<sup>15</sup> There have been three legislative acts that have driven organ procurement to its current framework of “encouraged volunteerism” in the United States: The 1968 Uniform Anatomical Gift Act; The 1987 Uniform Anatomical Gift Act; and The National Organ Transplant Act.

## The 1968 Uniform Anatomical Gift Act

In 1968, the National Conference of Commissioners on Uniform State Laws approved the Uniform Anatomical Gift Act (“UAGA”), which enabled anyone who was eighteen years of age or older and mentally competent the right to designate their organs for donation for transplant after they die.<sup>16</sup> By 1973 every state had enacted in whole or in part, some form of the UAGA.<sup>17</sup> The UAGA did not speak on the right of donors to be compensated for donation but did specify that the recipients must be “hospitals, doctors, medical and dental schools, universities, organ and tissue banks, and any specified individual in need of a transplant.”<sup>18</sup> Furthermore, the UAGA demanded that all donors have some sort of written documentation demonstrating their intent to donate their organs.<sup>19</sup> Despite the written documentation requirement, general medical

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<sup>14</sup>Gloria J. Banks, *Legal & Ethical Safeguards: Protection of Society's Most Vulnerable Participants in a Commercialized Organ Transplantation System*, 21 Am. J. L. & Med. 45, 64 (1995).

<sup>15</sup>*See Id.*

<sup>16</sup>*See* Jefferies, 5 Ind. J. Global Legal Stud. at 625.

<sup>17</sup>*See e.g.* (Missouri) Mo. Rev. Stat. §§ 194.210—194.307; (California) CA: U.S.C.A. Const. Amend. 14; West's Ann. Cal. Health & Safety Code § 7156.5; and (Kansas) K.S.A. 65-3209.

<sup>18</sup>Melissa N. Kurnit, *Organ Donation in the United States: Can We Learn From Successes Abroad?*, 17 B.C. Int'l & Comp. L. Rev. 405, 427 (1994).

<sup>19</sup>*See* Banks, 21 Am. J. L. & Med. at 66.



practice usually has the doctor asking the surviving family members for consent for organ procurement regardless of the presence of written documentation or not.<sup>20</sup> Even today, where a deceased donor has signed an organ donation card, the doctor will not proceed with harvesting the deceased's organs if the family has refused to authorize the removal of the organs.<sup>21</sup>

Although the UAGA was praised because it “encouraged socially desirable virtues such as altruism and benevolence without running the risk of abusing individual rights,”<sup>22</sup> it had little effect in increasing organ procurement and supply.<sup>23</sup>

## The 1987 Uniform Anatomical Gift Act

Reacting to the obvious failure of the 1968 UAGA to increase the organ supply, legislators made three important revisions to the UAGA in 1987. First, in an attempt to correct what was, in their estimation, the major deficiency of the 1968 Act, the 1987 Act included a “routine inquiry” provision which required all public and private hospitals to inquire into the donor status of every patient at admission into the hospital.<sup>24</sup> Prior to this revision, doctors had been unsurprisingly averse to asking next of kin to donate organs during the heartrending and tragic period following the death of their loved one. This revision was an attempt to overcome this reluctance of medical personnel to ask the next of kin whether they would consent to the donation of the deceased's organs.<sup>25</sup>

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<sup>20</sup>See Theodore Silver, *The Case for a Post-Mortem Organ Draft and a Proposed Model Organ Draft Act*, 68 UDDA 681, 697 (1988).

<sup>21</sup>See Harvard Law Review Association, *Developments in the Law – Medical Technology and the Law: Organ Transplantation*, 103 Harv. L. Rev. 1614, 1619 (1990).

<sup>22</sup>*Id.*

<sup>23</sup>*Id.*

<sup>24</sup>See Brian G. Hannemann, *Body Parts and Property Rights: A New Commodity for the 1990s*, 22 Sw. U. L. Rev. 399, 410 (1993).

<sup>25</sup>See Jefferies, 5 Ind. J. Global Legal Stud. at 626.

The 1987 revisions to the UAGA also included a controversial “presumed consent” provision. This provision authorized coroners, medical examiners or local health officials to remove the organs of cadavers left in their custody for transplantation or therapeutic purposes if the officials didn’t have any knowledge of the decedent’s or qualifying next of kin’s objection.<sup>26</sup> This provision was attacked on constitutional grounds but the “presumed consent” provision was upheld primarily on the basis of the next of kin lacking a protected liberty, due process or property interest in the disposition of the deceased relative’s corpse.<sup>27</sup> “Presumed consent” was clearly an attempt to increase the organ supply by shifting the donation presumption from one of opting out on organ donation to opting in.

Lastly, the 1987 UAGA revisions, expressly prohibited the sale of organs for transplantation purposes. Thus, any compensation received by the donor for his organ was now illegal. As in the 1968 Act, the 1987 revisions to the UAGA aimed at increasing organ donations again failed to increase the organ supply significantly. Most notably, while the “presumed consent” provision should have theoretically led to a significant increase in available organs, in practice the provision barely had an effect. Medical examiners, health officials and coroners rarely harvested organs under the auspices of the provision partly because of its seemingly shaky legal basis and the overriding reluctance reflected in practice and attitudes of medical personnel to do so without the prior consent of the deceased or the next of kin.<sup>28</sup> Furthermore, there were serious practical impediments such as maintaining organ viability that were reinforced by the lack of financial incentives for the donor or medical personnel. Hence, unlike in other countries such as Austria or Belgium, the “presumed consent” provision has proved to have little effect in raising the organ supply in the United States.

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<sup>26</sup>See Banks, 21 Am. J. L. & Med. at 67.

<sup>27</sup>See *State v. Powell*, 497 So. 2d 1188 (Fla 1986), cert. denied, 481 U.S. 1059 (1987).

<sup>28</sup>See Banks, 21 Am. J. L. & Med. at 68.

## The National Organ Transplant Act

In 1984 the federal government responded to the burgeoning organ supply crisis with the National Organ Transplant Act (“NOTA”). NOTA had two purposes: 1) make the sale of organs a federal crime; and 2) reinforce the position outlined in the 1968 UAGA that the structure for organ procurement in the United States would be “encouraged volunteerism.”<sup>29</sup> The legislation notably exempted replenishable tissues (e.g. blood, ova) from its coverage. Furthermore, NOTA also set up a national network to enhance organ procurement and education on a nation-wide basis. Echoing the lack of efficacy of the UAGA and its revisions, NOTA too failed to increase the supply of organs.<sup>30</sup>

### The Failure of the Legislative Approach

The failure of the 1968 UAGA, its revisions in 1987 and NOTA to increase the transplantable organ supply can be partially attributed to practical impediments. For instance, although the 1987 UAGA revisions attempted to remedy medical personnel’s reluctance to ask the next of kin for consent with the “routine inquiry” provision, there is still widespread disinclination on the part of medical personnel to ask.<sup>31</sup> Moreover, medical personnel’s deference to the next of kin’s refusal to permit doctor’s from taking the deceased’s organs even when the deceased has signed a donor card demonstrates another practical failing. Furthermore, it reveals that the underlying purpose of the UAGA to enable individuals to control the disposition of their bodies is not being realized.

These practical failings stem from an inherent flaw in the framework of the organ procurement scheme

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<sup>29</sup>See Jefferies, 5 Ind. J. Global Legal Stud. at 626.

<sup>30</sup>*Id.*

<sup>31</sup>See *Id.*

in the United States, namely that the underlying premise of “encouraged volunteerism” is incapable of increasing the organ supply significantly because it ignores the necessity of incentives. In other words, the sum of United States legislation on organ donation has retarded organ donation by prohibiting valuable consideration. In fact, one may view the current status quo as enabling everyone but the donor to receive valuable consideration (e.g. the hospitals get paid for the harvesting and corresponding transplant, the donee gets the organ, etc.). Clearly, “encouraged volunteerism” doesn’t work because incentives are not present among any of the participants for it to work. Although visions of a virtuous and generous citizenry may dance in legislators heads this does not comport with reality where most people have little desire to part with their organs even when they clearly no longer have a use for them. People are averse to donating organs for a number of reasons. Some of the most widely stated are: opposition to donate due to religious belief; denial of mortality; fear that medical personnel will not fully devote themselves to saving the donor’s life when there is an available organ for transplant; and simple disgust at the idea of having an organ removed.<sup>32</sup> Yet the prime reason people are reluctant to donate their organs is that there is no incentive beyond altruism. The right amount of compensation could overcome any of the above-mentioned reasons individuals choose not to donate.

Even in those infrequent instances where individuals are willing to part with their organs after death, those that would be in a position to approve and harvest the organs have no incentive to do so. It has been well documented that doctors widely consider maintaining a brain-dead patient in order to harvest their organs a heavy psychological burden.<sup>33</sup> Furthermore, the doctor has no incentive to counter the likely potential of upsetting the next of kin with the request. Similarly, the next of kin lacks an incentive to permit the organ donation considering they would likely rather keep the body “whole” for burial or crematory purposes. Therefore, disincentives are laced throughout the framework and the actors are consistently disinclined to

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<sup>32</sup>See Kurnit, 17 B.C. Int’l & Comp. L. Rev. at 428.

<sup>33</sup>See Lloyd R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market*, 58 Geo. Wash. L. Rev. 1, 13 (1989).

increase the organ supply. Clearly, the actors need to be given a reason, i.e. an incentive, to contribute their organs or to aid in the contribution of others' organs in the face of their reluctance to do so. Even the most reluctant will overcome their reluctance to do something when an incentive (such as monetary compensation) is provided for doing such thing.

If incentives are provided the practical impediments to increasing the organ supply will fall away. For example, if the next of kin could be compensated for the organs of their deceased relative, the next of kin will be more likely to consent to donation. Moreover, doctors will have a reason to ask as it could clearly be in the best interests of the next of kin. Other practical impediments such as willing donors failing to carry their donation cards will be alleviated as donors will have a clear inducement to be responsible and carry their cards if it would mean compensation to their families if they did so. The critical factor is putting in place concrete incentives (i.e. those that go beyond hazy notions of altruism) that encourage people to provide their organs.

## **“Presumed Consent”: An Alternative Solution?**

The most notable alternative attempt at remedying the lacking supply of organs has been the “presumed consent” system.<sup>34</sup> Variations of this system have been tried in European countries with differing results. In essence, “presumed consent” is an opt-out system in which the deceased has been presumed to give consent

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<sup>34</sup>As mentioned above, the UAGA does contain a “presumed consent” provision but the United States experience under “presumed consent” has been thoroughly lacking primarily do to its overly weak application in practice.

to the harvesting of their organs despite any unequivocal confirmation of doing so. Therefore, counter to the American opt-in system where the donor must carry a signed donor card demonstrating their willingness to donate their organs, in a “presumed consent” system, the opposite is true, the deceased must carry some type of paperwork or must register in a national database confirming that they do not wish to be a donor. Absent evidence that the deceased opted out, medical professionals have authority to take their organs under the “presumed consent” of the deceased. The efficacy of this system has varied depending on how ‘pure’ the presumed consent system is. For instance, in France, where the organ procurement rate is one of the top six in Europe,<sup>35</sup> the effectiveness of presumed consent in obtaining transplantable organs is tempered by the duty of the medical professionals to make a reasonable and diligent effort to determine the deceased’s wishes, i.e. if there were any objections to organ donation provided to a national registry or provided to the next of kin.<sup>36</sup> This duty to make a reasonable effort to determine the individual’s wishes adds time to the detriment of the quality and viability of the organs. Furthermore, it provides the next of kin with input into the decision, which has resulted in 90.7% of the cases operating like the American voluntary system of organ procurement where the next of kin vetoes the presumed consent and does not permit organ procurement.<sup>37</sup> Hence, although the ‘weak’ presumed consent system in France has more effectively addressed the country’s organ deficit than the United States, there is still a gross difference between supply and demand.

Counter to the French system, Austria has a relatively “pure” system of presumed consent. Austrian medical professionals have no duty to look for records or inquire with the next of kin to determine the potential donor’s stance on donating their organs.<sup>38</sup> As one would expect, Austria has fared much better than other nations in procuring organs for donation.<sup>39</sup> Nevertheless, despite its “pure” system of presumed consent even Austria

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<sup>35</sup>See Kurnit, 17 B.C. Int’l & Comp. L. Rev. at 442.

<sup>36</sup>See Jeffries, 5 Ind. J. Global Legal Stud. at 631.

<sup>37</sup>Kurnit 17 B.C. Int’l & Comp. L. Rev. at 443.

<sup>38</sup>*Id.*

<sup>39</sup>*Id.*

has been unable to meet the organ demand of its citizens.<sup>40</sup>

## The Major Drawback to “Presumed Consent” in the United States

Regardless of the varying levels of effectiveness amongst countries in their utilization of differing types of presumed consent systems, it is clear that presumed consent as a framework is better at procuring organs than the “encouraged volunteerism” framework of the United States. One would surely agree that rather than having fifteen people die a day under an “encouraged volunteerism” arrangement it is surely better to have only ten die under a “presumed consent” system. So why not, at the very least, have the United States move to a presumed consent system? It is highly unlikely that the United States will move to a “presumed consent” system because the notion of “presumed consent” is at inflexible odds with American ideals of personal autonomy and individual liberty. This is counter to European notions of individual rights which are more prone to be curbed in favor of more communal and socialist ends. In Europe, “presumed consent” basically amounts to an individual’s body escheating to the government absent some clear documented proof to the contrary.<sup>41</sup> Implicit in this, is the idea that the government has some property right in the individual’s body. Yet as demonstrated by constitutional history, the United States has been consistently averse to any notions of the government having property rights in the individual’s body.<sup>42</sup> Recently in *Brotherton v. Cleveland*, the 6<sup>th</sup> Circuit held that removal of corneas from a deceased person’s eyes without any examination of the patient’s medical records to seek donation approval was an unconstitutional deprivation of property interests without due process of the law.<sup>43</sup> Furthermore, if “presumed consent” was demonstrated to completely

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<sup>40</sup> See Jason Altman, *Organ Transplantations: The Need for an International Organ Market*, 5 Touro Int’l L. Rev. 161, 168-169 (1994).

<sup>41</sup> See Cohen, 58 Geo. Wash. L. Rev. at 15

<sup>42</sup> See e.g., *Roe v. Wade*, 93 S. Ct. 705 (1973); *Planned Parenthood of Southeastern Pennsylvania v. Casen*, 112 S. Ct. 2791 (1992); *Cruzan v. Missouri Department of Health*, 110 S. Ct. 2841 (1990).

<sup>43</sup> *Brotherton v. Cleveland*, 923 F.2d 477, (6<sup>th</sup> Cir. 1991).

satisfy organ demand perhaps an exception to these strong notions of personal autonomy and individual liberty would be justified, yet as demonstrated in Europe, “presumed consent” while better than American “encouraged volunteerism,” has merely curbed a small portion of the demand for organs in those countries utilizing the system.

## The Market Solution

Currently the United States does not recognize the right of individuals to sell their own organs. With regard to the deceased, although the widespread view is that a small degree of property rights exist in a cadaver, enough for the deceased to control the decision whether their organs get donated or not, the right to sell these organs is also not permitted.<sup>44</sup> Under the federal National Organ Transplant Act, people who are paid money for their organs are subject to a fine of \$50,000, or five years in prison, or both.<sup>45</sup>

This paper advocates the repeal of the federal and state laws prohibiting the sale of organs. The rationale behind the existing prohibition is not clear. For instance, why is an individual permitted to sell his blood, semen or bone marrow but not his kidney? Moreover, this prohibition does not resonate with American constitutional precepts. The federal government should return to the notions of individual autonomy and personal liberty that this country was founded on by enabling individuals the full freedom of choice to trade, sell or donate their organs as they wish. The author recognizes that there is less political resistance (especially in the face of the growing organ deficit) to enabling the deceased to be compensated for their

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<sup>44</sup>See Paul A. Gerike, *Human Biological Material: A Proprietary Interest or Part of the Monistic Being?*, 17 Ohio N.U. L. Rev. 805, 812 (1991).

<sup>45</sup>42 U.S.C. §§ 273-274e.



organs and therefore this paper advocates that legislation enabling the deceased to be compensated should be put into effect immediately. Yet this paper argues that this is only the second best alternative and a stopgap solution. The only means to finally cure the organ deficit before science is able to manufacture organs abundantly is to permit living donors to sell their organs.

## Compensation for Organs Generally

The ban on the sale of organs has the effect of imposing a price of zero. When prices are zero, suppliers have little incentive to supply and therefore shortages are the natural consequence. Although critics of organ selling state that there are incentives beyond money, such as good will and self-satisfaction that serve as incentives to provide organs, thirty years of experience demonstrate that these hazy incentives are not enough. In order to raise the supply of organs, it is clearly necessary that donors receive some sort of consideration for the organs they are providing. India provides a pertinent example of the effects of enabling donors to receive compensation. Upon legalizing organ selling, the immediate supply of organs in India rose dramatically, enough to satisfy more than one-half of the existing demand.<sup>46</sup>

Beyond raising the supply of organs immediately, permitting donors to receive compensation for their organs also eliminates the arbitrary criteria chosen by doctors in selecting who is going to receive the donated organ. Due to the huge shortage of organs, medical personnel utilize arbitrary criteria to ration the access to supply. Although there may be a number of patients eligible to receive an organ on the basis of their organ failure, medical personnel choose between them by utilizing criteria such as marital status, number of dependants,

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<sup>46</sup>See John C. Goodman et. al., *Patient Power*, Washington D.C. Cato Institute (1992).

income, educational background, intelligence, employment record, etc.<sup>47</sup> These criteria amount to gauging the social worth of the recipient. In effect you have medical personnel deciding who is going to live and who is going to die. Permitting donors to receive compensation for their organs would raise the supply of organs and enable medical personnel to abandon utilizing arbitrary criteria resulting in the inequitable distribution of organs.

The primary criticism of donors receiving compensation for their organs lies in the potential for abuse and ethical condemnation. Concerns regarding the potential for abuse will be addressed when this paper details its arguments for organ selling for both living and deceased donors below. In regards to ethical objections, opponents of donors receiving compensation often cite ethics as the huge obstacle to effecting any compensation scheme. Yet not only are the ethics that these critics cite vague and seemingly arbitrary (e.g. “It just doesn’t feel right”) but these ethics, as unspecific and varied amongst individuals as they are should not be placed at the center of the debate. Although one can find a consensus on the ethics of the populous to not permit murder, the ethics surrounding compensation for organs carries diverse opinion. However, it seems that those that are against compensation for organs carry an ethical monopoly in the media condemning those who would provide their organs to those that would willingly, even enthusiastically pay a fee to get.<sup>48</sup> A recent study by United Network for Organ Sharing (UNOS), the current agency in charge of organ distribution, showed that nearly half of Americans are in favor of allowing some monetary incentives to be given to organ donors.<sup>49</sup> There has been an exaggeration of the public antipathy to compensating organ donors by who base criticisms in impractical ethical conservatism. When donors started receiving money for their blood there was the same sort of uproar, which quickly retreated in the face of widespread

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<sup>47</sup>See Jefferies 5 Ind. J. Global Legal Stud.at 640; *see also* New York State Task Force in Life and the Law, Transplantation in New York State: The Procurement and Distribution of Organs and Tissues (1988).

<sup>48</sup>See e.g. Arthur Caplan, “Paying for Organs for Transplantation, Breaking Bioethics: A Bad Idea that Just Won’t Die”, MSNBC, (visited January 22, 2002) <<http://www.msnbc.com/news/669090.asp?0si=->>; Atul Gawande, “Organ Peddling”, Slate, (visited February 1, 2002), <<http://slate.msn.com/?id=3680&entry=24110>>.

<sup>49</sup>See United Network of Organ Sharing, Newsroom, Critical Data (visited February 5, 2002) <[http://www.unos.org/Frame\\_default.asp?Category=Newsdata>](http://www.unos.org/Frame_default.asp?Category=Newsdata>).

commonsense.<sup>50</sup>

Furthermore, behind these ethical condemnations, the practical concrete arguments against compensating people for their organs are often sparse. Generally opponents simply have an indistinct “ethical squeamishness” against compensating donors for their organs.<sup>51</sup> Clearly something as indiscriminate as “ethical squeamishness” should not stand in the way of patients, on the edge of death, from receiving viable organs.

Critics also fear that offering compensation for organs threatens to turn human body parts into market commodities.<sup>52</sup> Yet organs already exist as commodities, in respect to them being desired things that are routinely transported from one place to another. Furthermore, how can we adhere to the misconceived, idealistic notion that the human body is priceless, when people are dying for lack of organs and we permit the selling of ova, blood and bone marrow.

## Paying the Deceased

Payment to the deceased for the procurement of their organs would not be a radical step for the government to authorize considering there would be little potential for abuse and the ethical arguments against it are,

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<sup>50</sup> See Banks, 21 Am. J. L. & Med. at 65.

<sup>51</sup> Richard Epstein, “Organ Peddling”, Slate, (visited February 1, 2002), <<http://slate.msn.com/?id=3680>>.

<sup>52</sup> See Sabin Russell, “Doctors Postpone Proposal to Pay for Organ Donations”, San Francisco Chronicle Online, (visited January 22, 2002) <<http://199.97.97.16/contWriter/yhd7/2001/12/05/medic/8475-0029-pat.nytimes.html>>.

as stated above, nebulous, hollow and relatively unimportant when considered against the burgeoning organ supply crisis. A substantial number of scholars have contributed ideas on how such a system would work<sup>53</sup> and the best approach should incorporate ideas from a number of them.

The new framework would be as follows; the estates of deceased donors would receive money payments relative to the organs harvested from their bodies. These payments would probably not be excessive as it would be unnecessary to pay an exorbitant fee for an organ that would no longer be utilized. Furthermore, the expected increase in supply of organs due to the monetary incentives would drive down costs further. Payments to the donor and administrative fees for running the program would be paid by the donee, (more likely their insurance company). Moreover, compensation to the deceased's estate provides incentives to the next of kin to permit organ procurement, thereby eliminating the problem of having had the deceased consent only to have the medical personnel fail to procure the organs due to the attendant wishes of the next of kin. Lastly, medical personnel will have an incentive to procure the organs not only because both the next of kin and the deceased have desired them to do so but the resulting benefits to the donee will conform with their medical principles as will the resulting fees from the transplantation operation. Critics may contend that this would encourage inequitable distribution of organs as the rich would be more likely to be able to pay and/or have insurance. Yet the supply available to the poor will not change as donations motivated by altruism will not be affected by donors receiving compensation for their organs as the poor will still get the same amount. Those that wish to donate their organs for free will continue to do so. Although some may have a problem with only the rich benefiting from this program, it is no different than the current status quo with other health care services and products. For instance, the rich get more access to life-saving AIDS drugs like AZT than the poor do.

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<sup>53</sup>See *e.g.*, Jeffries, 5 Ind. J. Global Legal Stud. at 636; Cohen, 58 Geo. Wash. L. Rev. at 23; Harris, 16 Issues L. & Med. 220.

Consent to harvest the deceased's organs for compensation will still be needed and in order to encourage potential donees to educate themselves on organ donation and provide consent an incentive will be needed here as well. This incentive could be provided in the form of people receiving a small subsidy on fees connected to obtaining or renewing their passports or drivers licenses. Rather than paying \$50 to renew their license, the potential donor would have the choice to only have to pay \$40 if they consented to having their organs harvested for compensation upon their death. Again, this subsidy would be paid by the donees, who considering their precarious state, would eagerly pay it.

## **Paying the Living Donor**

The best method to alleviate the organ supply problem is to permit living donors to sell those organs that they can continue to live healthy lives without (e.g. kidney, part of lung or liver, etc.). Considering more than half of those on transplant lists need kidneys, permitting the sale of kidneys, of which a person only needs one to live a healthy life, provides a win-win situation. Simply put, instead of one person living with two viable kidneys and one person dying without any, you have after the sale and transplant, two people living with one viable kidney each. In order to prevent abuse, donors would only be allowed to sell their kidney's to federally licensed organ banks. These organ banks would act as middlemen between the donors selling their organs and the donees and hospitals performing the transplants. In this capacity these organ banks would serve to avoid the abuse of the system that could occur, for instance, if donees tried to sell tainted or diseased organs, or minors or mentally incompetent people tried to sell their organs, or if criminals "body-snatched" (i.e. kidnapped) people in order to harvest their organs, etc.

What these organ banks would not do is prohibit poor people from selling their organs. Letting the poor sell their organs is the central criticism of many opponents of organ selling.<sup>54</sup> Critics assert that the poor will be unduly coerced into selling their organs and they will be taken advantage of to the benefit of the rich donees buying the organs. While these organs will be available to anyone that can pay, these critics are somewhat correct in their estimation that the poor, considering they need the money more, will be disproportionately persuaded to sell their organs. Yet what these critics in their ivory towers and fairy tale bubbles fail to realize is that 1) poor people get taken advantage of everyday far worse than this and 2) the money the poor receive for their organ will probably be more valuable to them than an organ they do not need to have to live a healthy life. The risks connected to selling a kidney are low. In fact, one study has equated the risk of living with one kidney as equivalent to letting a person drive sixteen miles to work and back.<sup>55</sup> Contrast this risk of living with one kidney and the profits that a poor person could secure for selling the kidney. Ascribing a low value of \$1,800 for a kidney (which is what a kidney currently goes for in India<sup>56</sup>), would still be highly significant to a poor person. It could mean a tuition bill for their children, a down payment on a home, etc. Just because a poor person is more likely to sell a kidney than a rich person does not reflect abuse, it reflects reality – poor people need the money more than the rich and this is fair manner for them to get it. Unlike in other circumstances (e.g. lack of healthcare available to the poor), at least in this case a poor person is receiving monetary compensation that could actually lead to the betterment of their life. Critics cloud the clarity of this fair quid pro quo with an “ethical squeamishness” and romantic egalitarian notions that are not applicable in today’s world. People selling their organs even if they are more likely to do so if they are poor does not reflect the moral and ethical quandary that opponents contend as these opponents fail to consider the tangible benefits that these donors receive in return, namely cash, that could

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<sup>54</sup> See e.g. Gawande, <<http://slate.msn.com/?id=3680&entry=24110>>; Caplan, <<http://www.msnbc.com/news/669090.asp?0si=->>>.

<sup>55</sup> The Gallup Organization, Inc., “The American Public’s Attitudes Toward Organ Donation and Transplantation,” conducted for The Partnership for Organ Donation, Boston, MA, February, 1993.

<sup>56</sup> See Goodman, Washington D.C. Cato Institute (1992).

have an immediate positive effect upon these donors lives.

## Conclusion

The organ deficit in America represents an ever-growing crisis that is begging for reform. The current framework of “encouraged volunteerism” has done little to grow the actual supply of organs and instead prescribes 15 people waiting on transplant lists to die everyday. These are deaths that could be easily avoided if those laws prohibiting the sale of organs were repealed. Simple economics tells us that incentivizing donors by enabling them to receive compensation for their organs would significantly increase the supply and thereby cure the organ deficit. Criticisms concerning the potential for abuse (primarily against the poor) and ethics are misguided and hollow. Not only do these criticisms on the one hand rely on ill-informed, idealistic yet impractical notions of what the world should be like (for instance failing to see the compensatory benefits flowing to the poor could quite likely lead to a net benefit for them when weighed against the loss of their organ) But also, on the other hand, these criticisms rely on nebulous, insubstantial estimations of ethics that do not comport with what the general population ascribes to or even more pertinent to those of the donor and the donee. Considering the gravity of the nations current organ deficit it is critical that legislators get beyond these relatively trifling concerns (especially minor, when considered against the death of more and more people simply due to lack of organs) and repeal the prohibition against people receiving some sort of concrete compensation for their organs.